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Loma Linda University Center for Christian Bioethics

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Update

YODER, SPOHN AND VENDEN AGREE ON NUCLEAR PACIFISM

Although most American Christians endorse the just-war tradition, they are actually following their government in its "national interest" orientation to total war, contended John Howard Yoder, keynote speaker for the concluding day of the Christian Faith and Nuclear Peace conference held in Loma Linda in November.

Yoder, a Mennonite professor of theology at Notre Dame University and a leading pacifist theorist, was one of three Christian thinkers who articulated contemporary options for thinking about war. In addition to Yoder's address on pacifism, Paul Seabury, an Episcopal political science professor from the University of California, Berkeley, contended for a just nuclear defense position. William Spohn, a professor of Christian ethics at the Jesuit School of Theology at Berkeley, discussed his church's just-war position. Yoder and Spohn found common ground on nuclear pacifism, the position that no cause is sufficiently important to warrant nuclear war. Many just-war advocates feel driven to this position because just-war criteria such as proportionality, discrimination and possibility of success are believed to outlaw nuclear war.

Louis Venden, senior pastor of the University Church of Seventh-day Adventists, added his voice to other conference presenters in a powerful sermon entitled "A Matter of Life and Death," delivered on the culminating day of the conference, Sabbath, November 15. Labeling nuclear armaments of both superpowers as "demonic," Venden challenged worshipers to decide between a commitment "to the cross or the bomb."

A volume of essays originating from the conference is planned. Both audio and video tapes of conference sessions are now available. For audio tapes, call American Cassette Ministries at 800-233-4450. For video tapes, contact Media Ministries at (714) 824-4570.

TRANSPLANT CONFERENCE PROBES MEDICAL NEED AND SUITABILITY

The fifty-four specialists from a variety of professions across the nation who convened at Loma Linda on November 17 and 18 for an invitational conference on ethics and justice in organ transplantation moved quickly toward a consensus that organ recipients should be selected on the basis of medical need and suitability. This agreement became the springboard for spirited discussions regarding the standard's meaning and scope.

Considerations of economic factors highlighted the current shortage of transplantable organs and the possibility that a greater supply might not reduce overall medical costs. The nonmedical monetary barrier that separates those who can pay for transplantation from those who cannot could become even more difficult if citizens do not share the costs through private or public insurance policies.

The ambiguity of medical "need" and "suitability" surfaced in discussions regarding the lifestyles or handicaps of some patients. Some apparently nonmedical criteria turned out to be therapeutically relevant while some medical criteria included value judgments that may not withstand scrutiny. And in some instances, the same person may not be the most in need of, as well as the most suitable for, a particular organ. Hence, though medical standards are obvious in most cases, in some borderline circumstances these criteria may be either wider or narrower than many assume.

When the discussions focused upon factors such as race, religion, nationality and the role of the media in organ distribution, it became apparent that some practices disregard medical criteria almost entirely. Some contend, for instance, that the organs they donate should be transplanted only into members of their own race, a request that some surgeons have honored. The United States now places nonresident foreigners on a different waiting list than residents who also need transplantable organs on the assumption that the nation should serve its own inhabitants first. And some have used the media to secure organs for their loved ones even though other patients may have had greater or earlier medical needs.

What can be concluded? Three things at least. First, professionals who deny patients transplantable organs for nonmedical reasons are not likely to enjoy the support of their colleagues. Second, the standards of medical need and suitability can include a broad range of considerations that genuinely pertain to surgical success. And finally, even widely used medical criteria should be scrutinized periodically in order to eliminate undetected prejudice.

A Review

LARGER ISSUES OF JUSTICE ARE STILL TROUBLESOME

Report of the Task Force on Organ Transplantation

A Report on the Project on Organ Transplantation

States could significantly increase the supply of donor organs by enacting required request legislation and adopting brain criteria for the legal definition of death, conclude two organ transplant study groups. The national Task Force on Organ Transplantation, mandated by a 1984 Congressional act, issued its comprehensive report last June, and the Hastings Center's Project on Organ Transplantation focused on procurement in its report issued in late 1985. Because organ shortage is acute and will become more severe as transplantation is perfected and extended, hospital personnel should be required to routinely request that relatives consider donation of the decedent's viable organs. Over forty states have now adopted brain-based criteria for determining death.

Update

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Viewing transplant organs as a "national resource" which are donated in a spirit of altruism and volunteerism for the public good, the national Task Force recommends that financial considerations should not bar an otherwise acceptable candidate from transplantation. Public and private health insurers should cover transplant costs, with the federal government setting up mechanisms for last resort funding. Professor James F. Childress, co-chairperson of the Task Force, contends that the integrity of the country's gift-based transplant system is compromised if the organs are not equally available to all medically eligible candidates regardless of ability to pay.

Concerned that some foreign citizens have jumped the transplantation queue, the Task Force stipulates that no transplant program should allocate more than ten percent of transplant kidneys to nonimmigrant aliens. Regarding extrarenal organs, nonimmigrant aliens may be placed on the bottom of the waiting list and only receive an organ if no other suitable recipient can be found. Although a minority of eight members dissented, feeling that kidneys should be allocated just as are extrarenal organs, the Task Force argued that for humanitarian reasons a portion of kidney transplants should be made available to non-nationals.

Although concern for justice informs the entire Task Force report, it is most evident in the discussion of selection criteria. If one patient possess an urgent need and another has a greater probability of success, who should get the available organ? In most cases the acute patient, but fair and public determination of such issues is of more concern to the Task Force than are definitive answers. Medical criteria should be of primary importance in establishing a waiting list. Although the Task Force rejects both race and gender as reasons for discrimination, the standards of age, lifestyle and social support are ambiguous. Citing the importance of physiology over chronological age, the Task Force urges that utmost caution be exercised in considering age to avoid unwarranted discrimination against older patients. Although lifestyles which include a heavy use of illicit drugs may significantly reduce the probability of successful transplantation, "compassion and uncertainty about the connection between many lifestyles and disease militate against" assigning low priority to candidates whose lifestyles have led to organ failure. Regarding social support, the Task Force recognizes that family support for the patient is extremely important, but suggests that even absence of a family is no reason to exclude a patient from evaluation.

Both the national Task Force and the Hastings Center study group are committed to a transplant program which adheres to widespread societal values: individual autonomy, family importance, dignity of the body and saving of life. Only through adherence to these values and thoughtful, public weighing of their individual priority can public confidence in transplantation be gained.

The Hastings Project report indicates that the public is well informed on organ transplantation, but its suspicion over whether aggressive treatment is assured to a critically injured identified donor has created "broad-scale opposition." A massive public education program related to driver's license checkoff cards is called for by the Project report.

If the two organ transplant study groups' recommendations are heeded, additional thousands of lives may be enhanced and saved. If the call for last resort governmental funding of transplantation is implemented, many poor and middle class citizens may receive a fair chance of obtaining life saving organs, and justice is well served. At least inequities at one level of health care justice will have been redressed.

However, larger issues of justice beyond the scope of the reports but nevertheless germane to the issue, raise their troublesome heads. How far should society go in funding costly, exotic technologies which aid relatively few? To put the issue rather starkly, is it fair to allocate scarce medical dollars to hundreds of ailing sixty-year-olds when thousands of six month old fetuses and six year old youngsters do without preventive programs which could help assure their own superior health in old age? Unless the health care budget is unlimited, trade-offs must be made; but which ones and for what reasons?

Advances in expensive medical technologies may soon force us to grapple with how we weigh at least two competing alternatives: 1) the deontological value of present lives that are palpably close, and 2) the utilitarian good of statistical lives that are morally distant. Although the equitable use of transplant organs is an important debate, it occurs in a broader, largely unexamined arena.

James W. Walters

NATIONAL TRANSPLANTATION NETWORK: UNOS OR NBC?

Senator Albert Gore, Jr.
Loma Linda University
17 November 1986

Two weeks ago, my office received urgent calls from the Governor's office in South Carolina and the Children's Defense Fund. Their request was a familiar and painful one. They were told that a child whose parents resided in South Carolina would die soon unless a liver donor could be found.

How could they help? If only they could get the child onto the national networks. Did they mean UNOS and NATCO? No, they meant ABC, CBS, and NBC. The transplant program had assured them that only through these national networks could they obtain an organ in time.

"We do now have a comprehensive national transplant policy. The national policy will be fully operational by the October 1, 1987 deadline."

My office receives calls like that almost every week. In fact, that day we also received frantic calls from the family of two-year-old Stephanie Clapham in San Diego who had just been told by the Department of Defense that Stephanie would be allowed to die because the heart transplant she needed was experimental and CHAMPUS would not pay for it.

Fortunately, that problem could be solved. I am pleased to announce that as of November 7 CHAMPUS now does pay for heart transplants. But the call underscores the tragic confusion that many transplant families still confront.

Seven months ago, during the taping of the PBS series "Managing Our Miracles," University of Pittsburgh transplant surgeon Tom Starzl argued, as do so many in this field, that it was nonsense to believe one could influence the organ allocation system. Whether through money, media exposure, or an agreement between a donor family and a recipient family, they claim, it just doesn't happen. Yet, look at what happened in the case of 15-year-old Felipe Garza and 14-year-old Donna Ashlock in Patterson, California, when Felipe arranged to have his heart donated to save Donna's life.

Recent events have convinced most Americans that the "system" can be manipulated. In such well-known cases as Baby Jesse, Alex Girard, and Jodi Bell, media exposure seems to have made a difference. Other cases where money or clandestine agreements may have made the difference are not as apparent but even more troubling.

"But let me add a note of caution. There is still much to do before victory can be claimed."

Public appeals have a time and place. An appeal very similar to these from a family in Tennessee in early 1983 sparked my interest in organ transplant policy. Hundreds of similar appeals in the months that followed the first Congressional hearings in April 1983 helped build the public consensus necessary to enact the National Organ Transplant Act of 1984.

Media appeals also highlight the difference between Congress's efforts to solve the transplant problem and the

"The priority system by law must be based on medical criteria. It must be blind to social criteria."

Reagan Administration's efforts to exploit it. Initial public appeals for donors by the President in cases such as Ashley Bailey were a compassionate human response to a very human problem. But for the White House to hold out

such appeals as its whole policy is simply irresponsible. It will not pass muster with the American people.

Despite the Administration's objections, we do now have a comprehensive national transplant policy, and the network is UNOS, not NBC.

The National Organ Transplant Act of 1984 laid the foundation of that policy. Last month, Congress reaffirmed the policy by passing transplant amendments as part of this year's reconciliation bill. I am confident that with the continued hard work of those who work in transplantation, the national policy will be fully operational by the October 1, 1987 deadline set in this year's amendments.

That we have come so far over the last four years is a testament to the many dedicated professionals who work in transplantation. They have made the system work despite the willy-nilly policies of the Health Care Financing Administration. They have demonstrated extraordinary leadership in seizing the opportunity provided them by the policy development process.

The national transplant policy in place today is not something Congress handed down to the transplant community. Congress may have provided the opportunity, but the success of the policy depended on the cooperation of the many various groups who work in transplantation. The policy we have today is *their* policy and it is one they can be proud of. I know I am proud of the job they have done, and I am certain the American people will share that feeling as they continue to see the difference it is making.

But let me add a note of caution. There is still much to do before victory can be claimed. The laws we have passed are merely the tools requested by the transplant community to get the job done. They must now be wielded

"We simply must stick with medical criteria, or beyond that, random selection."

with the same skill transplant surgeons exhibit with their scalpels.

We must still deal with the bewildering Administration transplant policy. Unfortunately, so long as the White House stubbornly refuses to recognize the federal responsibility in this area, society's response to the problems posed by transplantation will be half-hearted at best.

The cornerstone of the national transplant policy is the new Organ Procurement and Transplantation Network established by the National Organ Transplant Act. The contract for the network was awarded September 30th of this year to the United Network for Organ Sharing (UNOS) located in Richmond, Virginia. That the award has only just taken place is evidence of the Administration's foot-dragging in this important policy area.

It came on the very last day the Administration could legally get away with it. A day later and the Administration would have violated the law prohibiting the impoundment of funds. It is so frustrating that despite the overwhelming mandate of the American people to get on with solving the problem, and despite constant pressure from the Congress to carry out the law, we are saddled with an Administration that simply refuses to take the plight of transplant patients seriously.

The network will maintain a single national list of all those in this country waiting for a transplant. More important, the network, through its broadly representative governance, must develop a system to prioritize the list of potential recipients. The priority system by law must be based on medical criteria, such as the urgency of the individual case and the likelihood of a successful outcome. It must be blind to social criteria. We don't want it weighing the relative value of saving a child with cerebral palsy versus saving an unusually gifted child.

The criteria must guarantee that individuals in comparable situations will be treated alike. If at the conclusion of the prioritizing process the system ends up with more than one suitable candidate for a donor organ and the decision is a toss-up, then we must be able to make certain that the recipient is in fact chosen at random.

I see that a major question on the conference agenda is "What kind of non-medical criteria should be considered" in

"Donated organs must be considered a national resource to be used for the public good. National sharing must be the rule not the exception."

selecting a recipient? Well, I hope you reject that notion. We simply must stick with medical criteria, or beyond that, random selection.

Making such a system work effectively won't be easy. Its success depends on everyone having the confidence that everyone else will play by the same rules. It won't work if we have a procurement program in Texas contracting with a procurement program in Colorado to get donors from Montana down to Texas.

Donated organs must be considered a national resource to be used for the public good. Organ procurement agencies' primary allegiance must be to the national transplantation network, not to the local transplant program or a procurement program four states away. While in some cases, because of ischemic times, it is appropriate to first look locally to place donor organs, in many other cases it is not. If we are to find organs for the many highly sensitized dialysis patients, and if we are to get the best donor/recipient matches, then national sharing must be the rule not the exception.

"The single most important issue continues to be the shortage of donors."

The transplant amendments Congress passed this year will make the system work better in a number of ways. First, we have finally provided Medicare coverage for immunosuppressive drugs. For years, Medicare has paid for kidney transplant surgery but then refused to cover the drug essential for the transplant to be a success, simply because the drug is self-administered on an out-patient basis.

Effective January 1st, patients who have their transplant paid for by Medicare will be entitled to 12 months coverage for these drugs. While many transplant patients must continue to take immunosuppressive drugs for the rest of their lives, transplant experts testified that a year's coverage would give 90 percent of transplant recipients the time necessary to return to work and be privately insured.

Despite all the numerous policy issues that have arisen in transplantation, the single most important issue continues to be the shortage of donors.

We have made progress. Since 1983, when transplant professionals and policymakers began taking steps to improve the donor system, the number of transplants performed has risen dramatically. From 1983 through 1985, the number of heart transplants jumped from 172 to 719, liver transplants went from 164 to 602, and kidney transplants increased from 6112 to 7695. But there is still much to do. Waiting lists are still long, and many die each year waiting for a donor, while studies show a potential for approximately 20,000 organ donors per year.

This year's law takes an historical step forward. Effective October 1, 1987, every U.S. hospital, as a condition of participation in the Medicare and Medicaid programs, must have written protocols to assure that families are made aware of the option of organ donation. This national "required request" law differs from many similar state laws by requiring the potential donor hospital to notify a federally certified organ procurement agency (OPA). The "required referral" provision was adopted after favorable review of a similar law in Tennessee.

Federal certification of OPAs is another key provision of the new law. The policy was strongly recommended by the Task Force of Organ Transplantation and the Inspector General of the Health Care Financing Administration.

As of October 1, 1987, to be eligible for Medicare or Medicaid reimbursement, all OPAs must be certified every two years as meeting certain standards. Included in the certifying standards are requirements that (1) OPAs be members and abide by the rules of the transplantation network, (2) OPAs must allocate organs within its service area using the same medically-based policies the network uses for national sharing, (3) only one OPA will be designated to operate within a given service area, (4) OPAs must be not-for-profit agencies, (5) OPAs will be required to meet minimum performance standards for the number of organs retrieved and the number of organs wasted, and (6) OPAs will need to have broad-based policy boards that assure community representation.

"We must put to rest stories of organs being shipped abroad when they could have been used in the U.S., or fears that your place on the list can be manipulated."

Finally, the 1986 transplant amendments require hospitals in which transplants are performed to also be members and abide by the rules of the network. Failure to do so will mean loss of all Medicare and Medicaid funding.

The new requirements placed on OPAs and hospitals performing transplants provide public accountability to organ recovery and sharing efforts. Public confidence in the system is essential. We cannot expect to see the number of donors increase if the public believes the system is unfair. Once and for all we must put to rest stories of organs being shipped abroad when they could have been used in the U.S., or fears that your place on the list of recipients can be manipulated by who you know, or how rich you are.

Another unresolved problem is the proliferation of transplant programs. We currently have several times more hospitals doing transplants than we need. This is bad for patients, bad for organ sharing, and bad for health care costs. Without a way to control the number of these programs, we will see the quality of transplant care decline, competition for organs increase, and the cost effectiveness of organ transplantation disappear altogether.

"We currently have several times more hospitals doing transplants than we need."

An approach that I have supported requires hospital to perform transplants at their own expense until such time as they can demonstrate they are able to maintain a successful program. I first proposed this approach in July 1983 in legislation mandating CHAMPUS coverage of liver transplants only at designated centers with proven programs.

"Only around ten of the approximately eighty medical centers now performing heart transplants will be eligible for Medicare reimbursement. It is a tough policy."

On October 17th of this year, that policy got a boost when Medicare, after years of prodding, finally announced coverage of heart transplants. Following the lead of CHAMPUS and Blue Shield of California, Medicare limited coverage to hospitals that have performed at least 12 heart transplants a year for the last two years, 12 before that, with a two-year survival rate of 68 percent. Only around ten of the approximately eighty medical centers now performing heart transplants will be eligible for Medicare reimbursement. It is a tough policy, but one I hope everyone in transplantation will vigorously support.

In the long run, the only way to preserve the miracle of transplantation for all Americans is to insist on quality we can afford. Unless we set standards for cost-effectiveness now, insurers may someday decide not to cover the operation and transplants will become only a privilege of the rich.

Organ transplants are one of the great success stories of America's health care system. If we continue to uphold the highest standard of quality and access, and insist on a truly national network for organ donors, the miracle of transplantation will grow more wondrous than ever.

A PHYSICIAN'S CALL TO PHYSICIANS

Robert Livingston, MD
Professor of Neurosciences
University of California at San Diego

I am going to assume that you are well-informed about nuclear war, about nuclear winter, about ozone depletion, about fallout, and I'm going to talk with you about physician responsibility. I'm going to assume that as physicians you have gone into the profession out of a commitment to giving care. I assume that what you have learned includes not only various ways of giving care directly and indirectly, but also consideration of the welfare of the patient in terms of his long-range health and survival risks and that you have had some degree of personal commitment as well as professional education relating to preventive medicine.

I believe that nuclear war is the great health and survival hazard of our day. There has never been anything equivalent. There's no way to imagine recovery of civilization or even, perhaps, survival of humanity if we have a nuclear war.

"What are you doing about the situation? What is your responsibility?"

In the great tradition of medicine, one of the responsibilities of a physician is to speak up to a patient, to a patient's family, to the community or the world.

Now my question to each individual is, "What are you doing about the situation? What is your responsibility in this context?"

"It's not just the President who has a button to push."

I'm not a scold. I'm here to ask you what you feel you *should* do, what you feel you *could* do, what you feel you *want* to do.

In thinking about this, think what you would lose if you didn't do something to prevent nuclear war. Think what you would gain if you did something. Even if we gave our best effort and failed we would not have lost anything already lost.

Think on it. Time is short. Weapons are ubiquitous. Many people control weapons. It's not just the President who has a button to push. The animosity that's expressed, the bitterness, the fear, the dodging, the propaganda, the exploitation that goes on, the people now dying of hunger and poverty who would be better cared for healthwise and otherwise if we weren't spending such atrocious amounts on these arms.

Star Wars would proport to be an umbrella to safeguard us. At best, it's fifteen years away. At best it is 90-95 percent perfect in terms of long-range missles. Buy an umbrella, cut out 5 percent of the cloth and stand in a rainstorm and see if you would like to pay for Star Wars.

But Star Wars does not take care of those weapons which come from submarines and low-flying aircraft, cruise missles, and so on. It does not safeguard itself in reference to its being decapitated very easily by a blast high in the atmosphere.

"I believe that nuclear war is the great health and survival hazard of our day."

The military people tell us quite frankly that nuclear weapons are not military weapons. They're weapons for deterrence.

Examine deterrence. You know something about deterrence. Draw a line in the pavement and tell somebody he must not step across the line or you'll hit him. Do it with your child or your spouse or try it in a traffic situation where you commit yourself and threaten destruction if he isn't deterred.

What happens when you do a deterrent act? It's simple. You lose control. The other person can step across the line. The other driver can come into the intersection. The child can expose you to the risk of your having either to back off from your threat, your deterrent, or make good on it. Either of those are very bitter lessons. What has happened to the superpowers is that they've both lost control. They are both frozen with fear. They both create enemies of the other.

"What happens when you do a deterrent act? It's simple. You lose control."

I went to the Soviet Union and as I walked in the park, as I gave lectures in medical centers, I said, "Are these the people that I want to kill with nuclear weapons? These lovers in the park? These picnickers? These people driving in the streets?"

I can't take it. I can't stand still as a physician. I call to you.

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Participants Needed for Abortion Conference

LLU's Ethics Center is contemplating a conference to be held in the Spring of 1988 regarding abortion in Seventh-day Adventist thought and life. Publishable scholarly papers from a variety of professions and perspectives will be needed in areas such as the following:

Descriptive Approaches

1. **Historical:** What were the convictions and practices regarding abortion among Adventists in the nineteenth century and in the first three quarters of the twentieth century?

2. **Sociological:** What are the attitudes and practices of contemporary S.D.A.'s regarding abortion and how are these related to variables such as age, gender, education, race, nationality, class, and marital status?

3. **Institutional:** What policies, protocols, and procedures now apply to abortion in S.D.A. institutions? How were they formulated and how are they administered?

Prescriptive Approaches

4. **Ethical:** What resources are there within Christianity as understood and lived by S.D.A.'s that can clarify the morality or immorality of abortion?

5. **Denominational:** In what ways can S.D.A.'s enhance the quality of their thinking and acting regarding abortion?

6. **Political:** How should the denomination relate to laws and customs regarding abortion in the world's various nations?

Individuals or institutions interested in participating in this conference as presenters, responders, or financial supporters are invited to contact the Center at their earliest convenience.

Participants in "The Heart of the Matter"

An Invitational Conference on Ethics and Justice in Organ Transplantation

Donald Anderson, MD
Loma Linda University

Leonard L. Bailey, MD
Loma Linda University

Bruce Branson, MD
Loma Linda University

Roy Branson, PhD
The Kennedy Institute of Ethics

John Burry, Jr.
Blue Cross/Blue Shield of Northern Ohio

Ronald Busuttil, MD, PhD
University of California, Los Angeles

W. Augustus Cheatham, MSW
Loma Linda University

Hillel Cohn, DMin
Congregation Emanu El

Thomas S. Culley, MD
Aetna Life Insurance Company

Richard P. Dwan
Advertising Council

Roger W. Evans, PhD
Battelle Human Affairs Research Centers

O. Howard Frazier, MD
University of Texas

William A. Gay, Jr., MD
University of Utah

Robert L. Hardesty, MD
University of Pittsburgh

Virginia Harwood, MA
University of Denver

J. Donald Hill, MD
Pacific Presbyterian Medical Center

David B. Hinshaw, MD
Loma Linda University

Stephen A. Jacobs
Jacobs & Company

Stuart Jamieson, MD
University of Minnesota

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Loma Linda Universtiy

Gerold Mande
Office of Senator Gore

Cheryl Mathis, RN
Loma Linda University

Constantine Mavroudis, MD
University of Louisville

Charles R. McCarthy, PhD
National Institute of Health

Robert Mendez, MD
University of Southern California

The Honorable Phil Morris
Fontana, California

June O'Connor, PhD
University of California

Sherianne Okawa, LCSW
Loma Linda University

D. Glenn Pennington, MD
St. Louis University

Jeff C. Pennington, Jr., MD
Regional Organ Procurement Agency

Jack Provonsha, MD, PhD
Loma Linda University

Keith Reemtsma, MD
Columbia University

Bruce Reitz, MD
John Hopkins University

J. Wesley Robb, PhD
University of Southern California

John A. Robertson, JD
University of Texas

Eric A. Rose, MD
Columbia University

Oscar Salvatierra, MD
University of California, San Francisco

Barbara Schulman, RN
Regional Organ Procurement Agency

Anthony Shaw, MD
University of California, Los Angeles

Earl E. Shelp, PhD
Baylor College of Medicine

Linda D. Sheaffer
Health and Human Services

George Strait
ABC Network Correspondent

Charles Teel, Jr., PhD
Loma Linda University

Robert Veatch, PhD
The Kennedy Institute of Ethics

Heather Vincent
ABC Nightline

James Walters, PhD
Loma Linda University

Gerald R. Winslow, PhD
Walla Walla College

Norman J. Woods, PhD
Loma Linda University

ETHICS CENTER
Division of Religion
Loma Linda University
Loma Linda, California 92350

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